

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 27 1957

11590
STATE FILE NUMBER

Registration District No. 300 Primary Registration District No. 6079 Registrar's No. 9

1. PLACE OF DEATH a. COUNTY <u>Reynolds</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Reynolds</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <u>Rockson Logan</u> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Ellington</u> <u>0900</u> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in 1b HOSPITAL OR INSTITUTION <u>Route 7</u> <u>4 YEARS</u>		d. STREET ADDRESS (If outside, give location) Reside on Farm <u>Rt 2</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>MARTELIA AMARILLIS Williams</u>			4. DATE OF DEATH Month Day Year <u>Nov 19 1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 27 1864</u>	9. AGE (In years last birthday) <u>93</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>22</u>	IF UNDER 24 HRS. Hours <u>48</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>GREEN CO. ARK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>BILLIE WILSON WIGGS</u>			14. MOTHER'S MAIDEN NAME <u>NANCY ANN HARDING</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>INEZ DE JOURNET, Rt 2, Ellington, Mo</u>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>2 wks</u> <u>480x</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Influenza</u>	
	DUE TO (c) <u>Senility</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Nov 12 to Nov 19 and last saw her alive on Nov 18
Death occurred at 6:00 P. m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deceased or title) <u>Kenneth T. Carles MD</u>	22b. ADDRESS <u>Ellington, Mo</u>	22c. DATE SIGNED <u>Nov 21/57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>11-21-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BERNIE CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>BERNIE MO.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>McSpadden FUNERAL HOME Ellington</u>	25. DATE RECD. BY LOCAL REG. <u>Nov. 21-57</u>	26. REGISTRAR'S SIGNATURE <u>Bessie Evans</u>
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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Received 11-25-57
Regents County Health Center
File No. 1157 - 24

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Allen C. McFarland*

Licensed Embalmer No. 454

P. O. Address *Van Buren*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
- If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.